STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
			B. WIN			10/10/	2013
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS			STREET ADDRESS, CITY, STATE, ZIP CODE 7365 E 16TH ST INDIANAPOLIS, IN 46219				
(X4) ID PREFIX TAG R000000	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	(X5) COMPLETION DATE
	Licensure Survinvestigation of IN00136103. Complaint # IN Substantiated. related to the a Date of Survey 2013 Facility number Provider number AIM number: N Survey Team: Courtney Mujic Beth Walsh, RI Tom Stauss, R Census bed typ Residential: 68 Total: 68 Census payor of Medicaid: 62 Other: 6 Total: 68 Sample: 7 These State fine	no deficiencies llegations are cited. : October 8, 9, 10, : 005729 er: 005729 l/A ; RN-TC N N De:		00000			
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	3	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/01/2013 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 10/10/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP 16TH ST	CODE	
CROWNPOINTE OF INDIANAPOLIS				APOLIS, IN 46219		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	accordance wit	th 410 IAC 16.2-5.				
		completed on October anelyn Kulik, RN.				

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 2 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		00	COMPLETED	
			A. BUI. B. WIN			10/10/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CDOMANI	DOINTE OF INDIAN	IADOLIC			16TH ST		
CROWN	POINTE OF INDIAN	IAPOLIS		INDIAN	IAPOLIS, IN 46219		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
R000192	410 IAC 16.2-5-1						
	•	andards - Nonconformance					
		all have a janitor's closet					
	•	ted on each resident					
	•	the facility. The janitor's					
		in a sink or floor receptacle					
		eaning supplies. The door set shall be equipped with					
		e locked when hazardous					
	materials are stor						
			ROO	00192	1.)The deficient practice as		10/29/2013
	Rased on obse	rvation, interview, and	100	001)2	identified as an unlocked janito	ors	10/29/2013
					closet on the East wing of the		
	record review, the facility failed to				second floor has been correcte	ed.	
	•	r's closet which stored			No residents were found to be		
	•	ardous chemicals was			affected by this unlocked door		
	closed and lock	red. This had the			All residents in the facility had		
	potential to affe	ect all 68 residents who			potential to have been affected	d by	
	resided in the fa	acility.			this deficient practice. 3) The		
		•			following corrections were made	de	
	Findings includ	۵.			to the door and its closing		
	i indings includ	C .			mechanism: The closing mechanism was adjusted		
	A 1 (:	10/0/0010 1.1.01			to ensure that the door will		
		, on 10/9/2013 at 1:04			automatically pull shut and a n	ew	
	•	the second floor			locking mechanism was install		
	janitor's closet,	located next to the			to ensure that the door will be		
	east wing seco	nd floor elevator, was			locked with each closure.4. All		
	open. Inside the	e closet on the floor			staff was in-serviced on 10/25	/13	
	=	r. The container, which			at a mandatory meeting on the		
		II, was labeled [name			importance of closing and lock		
	of company] Er	-			all work areas upon exit. 5. Th	ne	
		•			Director of Maintenance will		
	Counteractant.				monitor the door on all of his	<u>.</u>	
		1011010015			normal working days to ensure that it is functioning properly.	•	
		on 10/10/2013 at			that it is full clioning property.		
	10:01 a.m. of the	ne second floor					
	janitor's closet	indicated the door was					
	open. Inside the	e closet on the floor					
	•	r. The container, which					

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 3 of 9

[·			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/10/2013
N	NOT THE CO. ST. ST. ST.			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF			16TH ST	
CROWNI	POINTE OF INDIAN	NAPOLIS		IAPOLIS, IN 46219	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	was partially fu	II, was labeled [name			
	of company] E	nzymatic Odor			
	Counteractant.				
	An interview w	ith the Maintenance			
		/10/2013 at 2:34 p.m.,			
		loset was "his closet"			
		oset was "supposed to			
		ed and locked."			
	aiwaya be cios	ca ana ioonca.			
	Record review	of a Material Safety			
	Data Sheet, pr	-			
	, ·	on 10/10/2013 at 1:00			
		the "following hazards			
		•			
		lation or ingestion of			
	_	ompany] "Enzymatic			
		ctant" chemical			
		ointestinal irritation,			
		ng, diarrhea, nasal and			
		ation, dizziness,			
	nausea, heada	che, and possible			
	unconsciousne	ess or asphyxiation."			

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 4 of 9

TAG REG	SUMMARY STACH DEFICIEN		A. BUII B. WIN	STREET A 7365 E	ADDRESS, CITY, STATE, ZIP CODE 16TH ST APOLIS, IN 46219	10/10/2	2013
CROWNPOINTE (X4) ID PREFIX TAG REG	SUMMARY S'ACH DEFICIENGULATORY OR	IAPOLIS FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		7365 E INDIAN	16TH ST		
PREFIX (EATTAG REG	ACH DEFICIENGULATORY OR AC 16.2-5-4	CY MUST BE PRECEDED BY FULL		ID	Т		
Health (e) The the property of	rovision of recordered by hall be super premises of edication shad nursing partial on observation aides. It was a medical production of 2013 at 17 nistered production (Medicational), the manager are view were initial for hydroce 25 mg, for he slot for	(e)(1) Offense ation of medications and esidential nursing care shall the resident's physician ervised by a licensed nurse or on call as follows: all be administered by personnel or qualified rvation, interview, and the facility failed to dication as ordered by or 1 of 5 residents edication (Resident #49)		PREFIX TAG	1.)The deficient practice identification resident #49 cannot be corrected in arrears, a new ord has been received from the physician to update the medication administration times for the medication in question for Resident #49 Nother residents were found to have been affected.2.) All residents in the facility had the potential to have been affected.3.) In an ongoing effort to ensure compliance and quality assurance an in-service was conducted on 10/25/13 with all LPN's and QMA's, where a detailed review of the policy or Medication Administration was conducted by the HFA and Director of Healthcare Services (DHS).4.) Training will be ongowith clinical staff on a monthly basis to ensure that the Medication Administration Policis being followed and to ensure that all medications are then being given as directed by the physician's orders.5. In an effective of the policy or service or desired the physician's orders.5.	fied der lo by cy e	(X5) COMPLETION DATE 10/29/2013
_ ·		the date slots for			to monitor that the Medication		
10/1/	2013-10/8	/2013 on the same			Administration Policy is being		

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 5 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITT	DDIC	00	COMPL	ETED	
				LDING		10/10/	2013
			B. WIN				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
ODOMAN		IA DOLLO			16TH ST		
CROWN	POINTE OF INDIAN	NAPOLIS		INDIAN	APOLIS, IN 46219		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	line with the 2	and handwritten 1,			followed and that this deficient		
	indicating the r	nedication was given			practice does not occur again,		
	on those dates	•			DHS or her designee will cond	uct	
		and anno.			a visual inspection of all		
	Paviaw of the	October Physician's			medication administration reco on a monthly basis as evidence		
		•			by the updated rewrites. 6.) The		
		red there was an order			DHS or her designee will cond		
	1	ne/acetaminophen			a visual inspection of all		
	_ ,	illigram), 1 tablet by			medication orders for all new		
		daily at 8 a.m., 2 p.m.,			admitting residents and for all		
	8 p.m. The ord	der was initiated on			residents returning from a		
	3/27/2013.				hospital or SNF stay within one	е	
					week of return to the facility to ensure that all orders have be		
	Review of a do	ocument titled.			received and that all medication		
		mes Are As Followed,"			are being administrated as	1115	
		the Administrator, on			directed by physician's orders.		
		:15 p.m., indicated			This will be evidence by a		
		•			notation in the residents nursir	ng	
		tions were given at 11			notes.		
	a.m1 p.m. an						
		ere given at 1 p.m3					
	p.m.						
	During an inter	view with the Director					
	of Health Servi	ices (DHS), on					
		:27 p.m., she indicated					
	staff were expe						
		lers and was unsure					
		#49, was given the					
	1	•					
		11:35 a.m., when the					
	1	cian's Orders indicated					
		was to be given at 8					
		nd 8 p.m. She also					
		did notice how the MAR					
	had a handwrif	tten 1 in front of the 2					
	for hydrocodor	ne/acetaminophen					
	· ·	ministration slot. The					
	l		1				

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 6 of 9

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	e survey pleted 0/2013	
	PROVIDER OR SUPPLIER		7365 E	ADDRESS, CITY, STATE, ZIP (16TH ST IAPOLIS, IN 46219	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	if there was an	she would look to see other order in the nedication to be given tead of 2 p.m.				
	indicated she was given at 12 p.n ordered, but she looking. The D was going to c	s, at 9:49 a.m., the DHS was unable to locate an cove medication to be n., instead of 2 p.m., as ne was going to keep HS also indicated she all the MD (medical or clarify the order.				
	DHS indicated locate another timing of the al felt there was p	on 10/10/2013, the she was unable to order related to the bove medication, but brobably a mistake administration time of .				
	10/10/2013 at indicated wher MAR for Resid hydrocodone/amg was probap.m., instead of 10/1/2013-10/8 a handwritten there were initially slot. She also imiscommunical	rview, with LPN #2, on 11:36 a.m., she I looking at the October ent #49, acetaminophen 7.5/325 ably administered at 12 af 2 p.m., for the dates 8/2013, since there was 11" in front of the 2 and als in the date/time indicated there was a action regarding the ledication and the				

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 7 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE COMP! 10/10		
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF INDIANAPOLIS			7365 E	NDDRESS, CITY, STATE, ZIP CO 16TH ST APOLIS, IN 46219	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	timing of the admedication.	dministration of the				
	DHS indicated office to say the regarding the transport administration hydrocodone/arms and how the Order was written she was having for the medical Review of a post-definistration on 10/10/2013 "Residents of transport and tra	of acetaminophen 7.5/325 ne October Physician's ten. She also indicated g a new order written				
	was received to 10/10/2013 at the following man Resident #49) apap 7.5/325 man (symbol for character) (symbol for character) This is taking it (Name indicated it was at 12:50 p.m.,	sent to the MD office, by the DHS, on 2:27 p.m. It indicated nessage, "(Name of take [sic] hydrocodone ng P.O. (by mouth) 8a 2p 8p [sic] may we ange) times to 8a 12p how he has been to of DHS)." The fax is sent to the MD office on 10/10/2013, and back by the facility with				

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 8 of 9

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
			B. WING		10/10/2013
NAMEOUR	DOMDED OF GLIDN IE.			T ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	X		E 16TH ST	
	POINTE OF INDIAI			ANAPOLIS, IN 46219	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		at 2:24 p.m., on			
	10/1020/13.				

State Form Event ID: 6S6E11 Facility ID: 005729 If continuation sheet Page 9 of 9